ISG-Cultural Competency Committee
January 25, 2006
Meeting Minutes

Attendees: Julie Brown, Sherrie Collins, Gwenda Corman, Catherine Coscia, Victor Flores, Renaldo Fowler, Gloria Payne, Ramona Quihuiz, Kim Russell, William Santiago, Lilly Sly, Denis Viri, Jill Wendt, Rick Ybarra

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Welcome	Jill Wendt, M.Ed, ADHS/OCSHCN	Mrs. Wendt welcomed all the participants to the Integrated Services Grant/Cultural Competency Committee's January 2006 meeting. She informed the group that John Molina, Chairperson for the Committee, would not be in attendance, as he was under the weather. Hopefully, within our meeting today, we can address our goals and the tasks that have been outlined. We have a specific handout relating to this topic. Mrs. Wendt guided the committee through the agenda and the informational handouts for the meeting. Some of the handouts were printed directly from the website and can be reviewed, at your leisure, on our website www.azis.gov. We will concentrate today on the Community Action Planning handout which describes the Cultural Competency Committee's goals and tasks. We hope to put together some tasks that will achieve our goal.	*Website www.azis.gov
Introductions	Jill Wendt and Committee members	Ms. Wendt stated that along with the introductions today, Mr. Molina had expressed that he would like the members to also give a short self-profile on their cultural heritage. As the committee members introduced themselves, they provided a short background on their personal cultural heritage.	
Overview of the Integrated Services	Jill Wendt, M.Ed,	At the November 22, 2005 meeting, Dr. Jacquilyn Cox gave an Overview of the Integrated Services Grant. She went into specifics about the needs assessment and performance measures. The presentation is on our website and the information is also in your binder.	

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Grant	ADHS/OCSHCN	If you did not receive your blue binder at our first meeting or still need one, please make sure you get with me after the meeting. Please bring your binders to future meetings, as we will have handouts for insertion. I would like to go through some of the new handouts for the binders. At the first meeting, Victor Flores, Dr. Cox, Dr. Molina and I gave presentations. All of those presentations are available on our website. This committee is virtually advanced, so all the minutes and presentations will be on our website at www.azis.gov. The other committees within this Grant are: Quality Improvement Clinical Education and Training Specialty Services Insurance Parent Action Council Youth Action Council Those are the committees that make up the Integrated Services Grant and all these committees report to the main Task Force. If you are interested in another committee's functions, you can go online to review their minutes. Additionally, you can attend other committee meetings. It is a good opportunity to see what the other committees of the Grant are doing. It has been pointed out to me that it is important, as we go forward with our cultural competency, that we make sure that the other committees are integrating some of the ideas that we have into their methodologies. As the other committees write their strategies and plans, they need to have a cultural competent perspective built in. It is best for us to be aware of their plans at the beginning so we may help to bring cultural competency forward in a more appropriate way.	*Other Integrated Services Committees need to be aware of cultural competency.

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		At the beginning of each meeting, we will review the minutes from the previous meeting for corrections, and then move forward with the agenda.	*11-22-05 Meeting minutes handed out to members.
Informational Updates (handouts)	Jill Wendt, M.Ed.- ADHS/OCSHCN	What is currently being handed out is the "**Task Force and Committee Tasks**". This document breaks out what each committee, under the grant, is responsible for. Page three involves us. There is a lot to be done with our committee and we will talk about that today.	
		Participant Lists: Ms. Wendt advised the Committee to review the new Participant List to make sure that the individual information listed is updated and correct. Also, this is an updated list, so if you have one in your binder, please replace that old one with this new one.	
		Also , as a handout, and it may be in your binder already, is the **PPT presentation** Dr. Cox did on the **Overview of the Grant**. I want to make sure all of you get a copy of this, since some of you were not at the first meeting. This has a lot of information and is a good reference document. Also on our website www.azis.gov.	
Other handouts		*Website Home Page printout of the Cultural Competency SubCommittee. *Definition of Children and Youth with Special Health Care Needs (CYSHCN). *Committee Status Update-Draft (status updates are to be submitted to the Project Director by the first of each quarter) *Committee Action Planning Matrix (goals and elements)	
Tasks of Cultural Competency Committee: Goals and Elements	Jill Wendt, M.Ed., ADHS/OCSHCN	The handout we will be working with is the Community Action Planning Matrix. The cover sheet, entitled Community Action Planning, describes the format of the template used. The second page lists our Committee's goal and then listed below that, are the tasks to accomplish the goal. *Goal of Cultural Competency Committee*: To support participation of under-represented families in decision making, educational, and technical assistance activities.	

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		Tasks: 1) Support participation of traditionally under-represented families in decision-making, educational, and technical assistance activities. 2) Provide culturally appropriate education materials for parents and youth. 3) Ensure cultural competency and representation on the Task Force and all communities 4) Provide written documentation regarding the interplay of cultural and health care beliefs for children and youth with special health care needs 5) Engage individuals that are representative of the economic, racial, and ethnic diversity of their communities in the Task Force and committees. 6) Develop linguistic proficiency listing that can be used by all agencies for translation.	
	Jill Wendt, M.Ed., ADHS/OCSHCN	So this is our first assignment. The Executive Task Force is meeting February 16, 2006, and we will report to them our strategy for getting these tasks done. These are customized for our committee. As the form/table reads, the "Task" is defined for us. The "Outcome/Performance Measure(s)" is what performance measure will be satisfied by the task. The "Strategy" is the activities that we need to put in place and perform, to accomplish the task. "Action" is the step-by-step process. "Timeline" is how long it will take to implement and/or complete the task. What is the best way for us to do this as a group? Do you want to see how far we get with the tasks individually as a group, or do breakouts? The committee decided to go through the tasks as a group.	
	Jill Wendt, M.Ed., ADHS/OCSHCN	We probably won't get to all the tasks today. Number one is "support participation of traditionally under-represented families in decision-making, educational, and technical assistance activities". One of the current core tasks of OCSHCN is that we are developing two (2) new Parent Community Action teams in areas where there are traditionally under-represented families. We currently have 9 teams across the state. This	*OCSHCN developing 2 new Parent Community Action teams. One team

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		may satisfy this particular task already. One team will be on the Hopi Reservation in correlation with the Hopi Turtle Coalition. We have met with the Coalition and they are working with the community to develop a Parent Action Team. We have visited with them and developed action steps, and plan to follow through with future meetings. What other outcomes are we looking to achieve in under-served and under-represented communities and families? Ms. Wendt stated that a starting point may be to identify what and where we think the under-represented families are.	for Hopi Reservation has been defined and initial strategies outlined. *Where are the under-served and under-represented?
	Member Discussion	The members discussed "where to start". There cannot be a general approach to the specific populations because all the populations that we may address are special onto themselves, and will have different needs. Mr. Ybarra suggested that we, based on a behavioral health model, identify all the different advisory committees, and/or committee components and functions we already have in place and then look to see if we have consumer, family, and youth representation in those. If we want participation in decision-making, educational, and technical assistance activities, we need to look at what exists right now. Then determine if we have under-represented families and youth involved in the on-going activities. Ms. Wendt stated that task #2 is general in nature, "provide culturally appropriate education materials for parents and youth". Mr. Santiago stated that we need to teach the parents, youth, and consumer with culture relevancy on how to participate in education and healthcare. Ms. Wendt stated that education and healthcare are the two main entities that relate to children with special healthcare needs. Ms. Brown related her observations about the Tohono O'Odham Nation whereby there is not a large population at the children's clinic. The grandmothers take care of the children at home and they are not educated on	*Research Advisory Committees and other Committees currently in place *Specify populations that are under-represented.

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		where to go. Ms. Collins stated there is no "clearinghouse" for the family to go to with questions. For example, to obtain information on the deaf population. Mr. Fowler stated that at the first meeting we discussed "where can we provide parents and families with information" and also, teach parents how to work within the system that is already in place. As far as clearinghouse is concerned, the Arizona Department of Education has, within their Enhancing Arizona Parents (in their special education section), a website where a variety of agencies and organizations can register. When the parents go to the website, they can see a cohesive listing of agencies to contact for their concerns. That is a good resource that is in place. There are resources out there, but in no central location to span many topics that the parents are concerned with. A question was raised as to where the parent would go. Would this be at a school? The group discussed how schools could be of assistance for parents to access systems that may have clearinghouse information to provide. Ms. Sly stated that there is a responsibility to locate the kids and educate parents. A good tool is "Child Find" that is in place within the Education Department. It is federally funded and targets special education. It helps locate the kids that have potential disabilities and health issues (of any kind) and see if their particular need can be met. Ms. Sly suggested that we may be able to piggyback on this. We should look at what is already being done in schools whereby we may be able to link it. There are resources out there that will locate children with special needs, and maybe we just need to link into them. Mr. Flores pointed out that most of the under-represented families are rural and there is a wide cross-section to try and define. If we could define where these families are, what systems they access-if any, and then outline the	*Hearing loss clearinghouse (ASDB is limited in what they can provide) *Teach parents to advocate for themselves *Schools as places of referral * Help people access "a system" be it in healthcare or education (clearinghouse) *Child Find-develop linkage *Base population in need may be rural, non-English speaking, no

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		specific issues that affect them, we could answer the "why". We could address the concerns category-by-category. Ms. Corman stated that some of the Tribes don't even have Internet access but they can provide information to parents. She stated that the Health Fairs that are conducted on reservations help very much. The parents get the necessary information and get a chance to meet all the people involved. Ms. Russell mentioned the drop out rates on reservations. Some of the youth and parents don't even get involved in the school and what it has to offer because the youth are not in school. Mr. Viri suggested that there must be a follow-through and follow-up with the parents after they have come to ask for help. Many times we give the initial information but never guide them through the information. This is an area that must be concentrated on because it would seem that this is where the system (whatever system is trying to be put in place) fails. Ms. Wendt suggested a "cultural liaison" that is specific to that culture, that can continually help and assist the population in need. Ms. Collins advised the group that her office had a grant that addressed the need of a resource book/directory (topic specific to deaf and hard-of-hearing) on the Navajo, Hopi and San Carlos reservations.	internet access, and have transportation issues *Health Fairs on reservations have been successful *High drop out rates contribute to non-involvement at school level. *Information can be provided but follow-through and follow-up *must* be done *Place Cultural Liaisons to help follow-up of implemented programs. *Develop resource directory specific to community needs
		Ms. Collins also advised the group that Arizona will be hosting the National InterTribal Deaf Conference June 14th through June 17th, 2006.	*Ms. Collins will bring information on conference to next meeting.
	Member discussion (cont'd)	Mr. Fowler pointed out that we need to be realistic on when and what we decide to do. For example, what is done in Snowflake is different than what is done in Scottsdale. Identify what areas that will have the greatest impact and	*Do not take on too much in the communities that are in

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		what we *can* do. A systems' change recommendation may not always be appropriate based on the idea that people are so diverse. With Indian nations, it will get complex. As with the Spanish population too. It is urban area as well as rural. It can become very conflicting. We must look at the relationships already established, especially if they are federally based relationships. Ms. Wendt mentioned that we could use the healthcare system in place already as to the research that will need to be done. See how they are going about accessing current healthcare and see where the system may or may not breakdown. Ms. Brown raised the question as to whom or what would be our target people. Is it the parent, children, or the professional? It must be culturally competent, cohesive and comprehensive. She explained what Tohono O'odham had as far advertising different resources and organizations. Let them know we are out there. She also explained the term "medical home" and how that concept may be most appropriate to describe the networking that can and should be done. The goal is for the children's medical care tol be concentrated in one location. All of their records, etc. There are barriers still out there, but it has been mandated that by 2010, every title will have a medical home. Dr. Attico stated that the concept of medical home was advocated by the Academy of Pediatrics for all children. Something that is important with medical home is that you get continuity of care rather than episodic care of here, there, and everywhere. As it stands now, nothing (no information) gets back to the original record so the next provider knows what went on before. Dr. Attico stated that medical care has changed since he finished medical school a long time ago. It used to be "you made the decision, you told the patient what was going to be done". The doctor made the delineation and our	need. Benchmark and improve on what may be in place. Or research new projects that are innovative and will achieve expected results. *Defined Medical Home: 2010 Medical Home for all children, continuity of care vs. episodic care.

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		major responsibility was "do for the patient, what they can't do for themselves". In order to do that, you must teach the patient what the standards are. It is different today. You must teach them so they can make the choice so they can make the decisions. If they make the decision, they will make the value judgment about what they feel is appropriate in their situation. You may have to advocate for them to take bigger leaps, but they should still be making the decision. Ms. Wendt stated that it was a parent partnership. Dr. Attico reiterated yes, and they need to know enough about the system. But the system is so complicated, they can't even navigate. They need to know as much possible so they can decide their best path. We can build resources around this concept. Ms. Wendt asked how we go about selecting under served people and areas in the community, that we can identify as a group. We can have an overall vision but we do want to make a difference. Ms. Russell suggested that we find out how other agencies, communities and/or systems do outreach to their communities and how they provide services to urban people related to healthcare and health disparities. How do they outreach to a population. Find a community that is ready to outreach. Ms. Russell stated that she knows that reservations and tribes use their Community Health Center as a point of access to resources and to network but the urban American Indian population is overlooked. If we can find a tribal community in an urban setting, that is starting to establish an infrastructure, and help that community start a Resource Center. A pilot project in which other communities can look at and see its success. Work with one community that is ready to go forth.	*Families/patients make decision that include value judgments for what is appropriate in their situation. Parent partnerships. *Pilot program with a urban American Indian community that is ready to establish infrastructures – Pasqui Yaqui
	Jill Wendt, M.ED, ADHS/OCSHCN	What would a pilot program look like? A discussion took place on the under-served populations and possible pilot	

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	and Committee Members	project in a community. Ms. Russell stated to begin a dialogue with the grass-roots people. The champions of the community that can help identify the under-served population. Mr. Ybarra stated there would have to be some piloting eventually. To identify a community that has an interest, resources. Have a representative from a school district. It is information education and outreach that can be put into a Community Resource directory for children with special healthcare needs. Services they may be eligible for and how to go about getting these services. And then coming up with a directory and maintaining it. Identify by zip code, the hot spots. It is a good idea and I don't think there is anything out there like this.	*Community Resource Center (include directory).
		Ms. Brown mentioned that Behavioral Health (Lee Hunter) with their Community Teams, is doing a map of all the resources in the state. That may be a resource available.	*Behavioral Health Community Teams – resource map of State.
	Jill Wendt, M.Ed., ADHS/OCSHCN	A project that I know is going on and is in place, that we may be able add on to is the First Responder program in Prescott and Prescott Valley. They have it set up as a dispatch. If you have a special needs child that lives in your home; you register with this database, so that if 911 or the police get called; where they have behavioral health issues, they know beforehand, that someone that lives in that house is a special needs child and they know how to address the people and the situation better. We could put a cultural competency/diversity twist to an existing program.	*Prescott Valley's First Responder Program – work with existing program to make culturally competent.
	Gloria Payne, Sickle Cell Program Manager, ADHS-OCSHCN	In identifying resources, we need to ask the right questions. Questions as to where to go to identify the people in crisis. Some of these populations have chronic disease or pain. In my experience and programs from OCSHCN, we sometimes hear "this population is too difficult to maintain", "what do we do with them". Or it is too diverse. We need to find something that will identify the people in crisis and more importantly, people with special needs. Where these people can go and not get classified or even diagnosed wrong. Ms. Wendt stated that all the OCSHCN staff learned so much from the Sickle Cell Program presentation this past January. We could develop materials around that. Education, nurses, schools, healthcare-there is a lot that we could	*Pilot study/project on Sickle Cell Program; (transition from the

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		take on. Start at a hospital or community. Mr. Fowler asked where the OCSHCN Sickle Cell Program was operating. Ms. Payne stated that OCSHCN is operating the Program at Phoenix Children's Hospital and St. Joseph's. CRS has a clinic that serves Sickle Cell as well. Ms. Payne stated that we have no transition from our program to what is next. To make sure they get care. The adult population of 15 to 20 years old.	program to adulthood)
	Julie Brown, Parent Leader	Question was raised as to what the committee was trying to be culturally competent with and/or in.	
	Jill Wendt, M.Ed., ADHS/OCSHCN	The grant reads that we will serve as the voice for the traditionally under-represented and under-served people and to ensure that mechanisms are in place to reach out to them. We are charged with the task of making sure that happens in a culturally competent way. Ms. Wendt related her experience in college as a case manager to a Pascua Yaqui family where a little girl had a seizure disorder and how therapists would not even go to the house because it was dirty and on a reservation. That is a cultural barrier. We are not going to be able to solve all the problems but we can certainly provide education to the families and professionals of an under-represented population. Our Behavioral Health RBHA's have a cultural competency plan whereby the have the infrastructure is in place. We could link to this. It is wise to take a local community, and Pascua Yaqui may be an opportunity for a project. Maybe setting up the resource library. Mr. Ybarra stated that Bill Rosenfeld has a nationally recognized Integrated Primary Care Behavioral Health program that is doing well. There are opportunities to move in many directions. A local pilot, from a Behavioral Health standpoint, we can collaborate. They do a lot at the schools and the prevention people provide a lot of educational materials. We can link this as soon as we identify the population we are trying to penetrate. Ms. Russell reiterated to find the champions of the community, but an urban community would be better if we are looking at the Native American culture.	*Benchmark on RBHA's culturally competency plans already in place. *Pascua Yaqui as a community project. *Resource Library *Link with Integrated Primary Care Behavioral Health programs (Bill Rosenfeld) *Urban Native Americans as a community

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		Mr. Flores stated that identifying and piloting can be done. We do it in Behavioral Health. We compare the universal elements to the penetration rate and we identify where the disparities are occurring. We have a formula that is used and could be applied in a project. Dr. Attico stated that we need to look at the health disparity as a key. We tend to look at health disparity and then blame the victim instead of saying "this needs to be done next, etc". Indian Health Center is funded at 55-60% on need and that is ridiculous. And when they go for more funding, it becomes a political problem. You cannot expect things to be improved if you are not putting anything in there to improve it. The systems of Public Health Nurses and Community Health Representatives are extremely important as they give the families education, helps in ChildFind, and helps getting the people to get their needs met. You put everything into the front end and do not follow through with other parts. And then the victims get blamed.	*Mindful of health disparities that will not end up blaming the victim. *Systems in place with Public Health Nurses and Community Health Representatives.
	Jill Wendt, M.Ed., ADHS/OCSHCN and Committee Members	We have about 30 minutes. We need to talk about how often we are going to meet. Do we want to start on some these projects that have been mentioned? Mr. Fowler stated that we want to make the systems more responsive to parents and families. That is a systems change. Are we talking about systems change or individual change? We need to look at both -making the system responsive and giving parents tools to navigate that system. We do this in different ways. For example, a couple years ago, I was talking to a special education director in a school district and her complaint was the lack of parental involvement and participation in special education. Poor parent response to meetings. One change was made, and that was hiring of a parent liaison who spoke the language. In that, they went from 20% parent attendance to 80%. Is that the system more responsive to the parent or the parent empowered?	*System more responsive to families and parents. *System change vs. individual attitude change *Tools for parents to navigate system
	Lillie Sly, Associate Superintendent	Ms. Sly stated that the little things we do make the difference. We need to be more culturally aware and respectful of the groups we already serve, and of who and what is out there. Agencies and groups are in place to reach people	*Powerful message with compassion. Not too much, small can make a

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	ADOE	and build relationships. Educate the people about the delivery of services. Research has shown that one person makes a difference. Key factors are empowerment and value. I would like to see this committee be human. I do not see this group doing a lot of projects. I see us looking at the people who are doing the work out there and trying to find a way to inspire them to do what they should be doing, to do what they are getting paid to do. But respecting people as we do it. This person has a need, and I need to help that person with that particular need. There are all kinds of groups out there, could we inspire them to develop other skills and go out with the mentality that "I have the ability to bring out the best in this group"? That is providing a service. The directory idea, clearinghouses, web-based mechanisms are all excellent ideas but remember not everyone has internet access, etc. The group we may target, we must remember, have limited resources. And we need to respect them. We can take something small and make it magnificent. Mr. Fowler stated that we have many agencies out there in regards to children with special health care needs. These agencies/staff are talking about changing the way they do things in terms of providing services. When I say system change and individual change; it is attitude change, policy change, managerial changes. But I am trying to think that, with the people that provide, do they do training while they implement the change? Is there diversity training with the staff, etc.? How do you change attitude in terms of culture and implementation of services? Mr. Flores gave an example of the Community Council on Culture that is in place at the Community Partnership of Southern Arizona. It has authority and contributes a lot of ideas and energy, and we use it as a framework to start putting the real focus on cultural issues. To include all our stakeholders in the system of care, on a specific cultural group, and to get the "buy in". In this example, once I had the buy in, I identified a person from each of the stakeholder's system that would be a point of cultural contact to report out to all the systems. That included dissemination of information on training, the monitoring, the case management, technical assistance-- in order to make sure	difference. Inspire groups already out there. *Broken Window Theory-not reaching people, relationships, trust. Educate people that are delivering the services. Provide education materials and become more culturally aware of the groups we already serve. *Community Council on Culture framework and accountability as benchmarks. *Learning Management system *Cultural Broker *Must be accountable

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		people were held accountable. Real tangible things that needed to happen They became very goal orientated and it is now a requirement that they report monthly. And since it is a requirement now, there are sanctions too. So we must look at holding accountability. Mr. Ybarra stated that this is a leadership concept. ValueOptions has new leadership, for those who don't know. We have a new CEO and new leadership in our Children's Division. We work in many areas but we are always looking to improve. To work in partnership with groups like this is a goal. There is so much need out there and these activities are worthwhile. We can work together to come up with something that will have a positive impact and replicate it in other areas and systems. We can show the other RBHAs what we are doing. It is rare that a group like this exists that represents so many different areas, and has a sole purpose and focus. We are breaking new ground here and it is an exciting endeavor.	
	Jill Wendt, M.Ed., ADHS/OCSHCN	This is why we have been created. Thank you Rick. We have, as one of the committees, the Parent Action Council, and they met for the first time this month. They are all parents of special needs children. We could get feedback on their needs and maybe there are some identifying tasks that they will do whereby we could incorporate some of our cultural aspects into. Mr. Ybarra stated that, eventually, if we move onto a pilot program, we have to focus on the whole customer service piece. There is so much that intertwines with cultural competency when it comes to customer service. How is the first engagement, when you walk in-what's on the walls, the phone, how is one greeted. That is cultural competency, and if you do not have those aspects in place already, then you aren't practicing it. Those are some tangible things we can look at to ensure that whatever direction we move, there are some core things we can focus on. The recipe for the cake you want to make and we can outline what that recipe is. There will be a training piece that will be important to the pilot project, whatever it will be.	*Jill Wendt to review Parent Action Council meeting minutes for possible feedback and incorporation of ideas. *Pilot program/study should concentrate on customer service at front-end of process.

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		They need to know how to engage people, the issues and needs, the similarities and differences, and how to link them properly and satisfactorily. These are some activities that will need to take place.	
	Jill Wendt, M.Ed., ADHS/OCSHCN	Jill stated that what Ms. Sly said was very important. We can take the opportunity to inspire and make a difference. Ms. Wendt referenced the recent Sickle Cell presentation that was made to the OCSHCN staff. Most of the attendees did NOT know the specifics on sickle cell and what children go through, and what issues confront the families. It was inspiring and it changed people's lives in a short amount of time. Ms. Wendt stated, that this summer, the OCSHCN Department will be doing a "poverty training". It will have a 500 people limit. In regards to this, we felt the biggest impact was to train our contractors so that they are operating in a way that is appropriate for people living in impoverish areas. We will do that, for a day, to make an impact and inspire. So when a therapist chooses not to see a little girl, they will take a minute and look at why. I know our schedules are busy but I need a vote on every other month or monthly? The members agreed that, for a start, the meetings should be held monthly. For the next meeting, I want you to list the three things that you got out of this meeting today. Three ideas that you would like our committee to give more thought to. Please email to me and bring to the next meeting. For the next meeting we will get a bit more specific in outlining the tasks listed. Thank you all for coming.	* OCSHCN Poverty-training seminar in summer 2006. *Initially, Cultural Competency Committee will meet monthly. *Members to email Jill Wendt 3 specific ideas for committee to possibly work on. Will bring ideas to next meeting.
Next Meeting		**To be determined.**	March 8, 2006 1-3:00